TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
JOSE TREVINO, MD

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-17-0129-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
SEPTEMBER 16, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to your EOB the service was not furnished directly to the patient and/or not documented. It is clearly noted in the medical note for this DOS under the section tilted RADIOLOGY that an X-Ray of the right foot consisting of two views was provided to the patient."

Amount in Dispute: $65.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 13, 2015	CPT Code 73660 Toe X-Ray	$65.00	$44.03

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 11-(112) Service not furnished directly to the patient and/or not documented.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - W3-Request for reconsideration.

- Z710-Code description not listed.

4. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on September 26, 2016. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review

Issues

Does the documentation support billing CPT code 73660? Is the requestor entitled to reimbursement?

Findings

The issue in dispute is whether the requestor is due reimbursement for CPT code 73660-T9 per 28 Texas Administrative Code §134.203. The respondent denied reimbursement for CPT code 73660-T9 based upon "(112) Service not furnished directly to the patient and/or not documented."

CPT code 73660 is defined as "Radiologic examination; toe(s), minimum of 2 views." The requestor appended modifier "T9-Right foot, 5th digit" to code 73660.

The requestor contends that reimbursement is due because "It is clearly noted in the medical note for this DOS under the section tilted RADIOLOGY that an X-Ray of the right foot consisting of two views was provided to the patient." In support of the position, the requestor submitted the November 13, 2015 report that supports x-rays were performed on the toes; therefore, the documentation supports billed service and reimbursement per the medical fee guideline is recommended.

The fee guidelines for professional services are found in 28 Texas Administrative Code §134.203.

Per 28 Texas Administrative Code §134.203(c)(1)(2),

> To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
>
> (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.
>
> (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007.

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2015 DWC conversion factor for this service is 56.2.

The Medicare Conversion Factor is 35.9335.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75247, which is located in Dallas, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Dallas, Texas".

The Medicare Participating Amount is $28.15.

Using the above formula, the Division finds the MAR is $44.03. The respondent paid $0.00. The difference between the MAR and amount paid is $44.03; this amount is recommended in reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $44.03.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $44.03 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		11/03/2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.